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 BY WESTERN DISTRICT OF WASHINGTON
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2. Complete the form.
3. Print, sign the document, and file with the court.

5
 6 UNITED STATES DISTRICT COURT FOR THE
 7 WESTERN DISTRICT OF WASHINGTON

8
 9 The Estate of Mark David Turnage, Jr.

10 Plaintiff(s)

11 vs.

12 Valley Medical Center, Sound
 Physicians, Dr. Mary Vancleave, Dr. C.
 Gabriel Alperovich, Southlake Clinic,
 Dr. Frank Thomas, et. al.

13 Defendant(s),

C14 - 0075 RSM

CIVIL RIGHT COMPLAINT UNDER

42 U.S.C. §1983

(for use only by plaintiffs not in custody)

14
 15 Parties to this Complaint:

16 Plaintiff's
 Name, The Estate of Mark David Turnage, Jr.
 Address and Karie Fugate, Personal Representative
 Phone 2417 NE 23rd Street
 Number Renton, WA 98056

19 Defendant's
 Name, Valley Medical Center
 Address and 400 South 43rd Street
 Phone Renton, WA 98055-5010
 Number (425) 228-3450



14-CV-00075-CMP

23 Defendant's
 Name, Dr. C. Gabriel Alperovich
 Address and 24604 104th Ave SE, Suite 201
 Phone Kent, WA 98030
 Number (253) 220-8091

1 Defendant's
2 Name,
3 Address and
4 Phone
5 Number

Dr. Mary Vancleave
Swedish/Edmonds
21601 76th Ave W / 2E
Edmonds, WA 98026
(425) 640-4000

6
7 (If you have more defendants, list them using the same outline on another piece of paper.
8 Attach additional sheets, if necessary)

9 **Previous Lawsuits:**

10 Have you brought any other lawsuits in any federal court in the United States?:

11 No Yes

12 If Yes, how many?

13 **Describe the lawsuit:**

14 Parties to this previous lawsuit:

15 Plaintiff(s)

16 Defendant(s)

17 (If there is more than one previous lawsuit, describe the additional lawsuits on another
18 piece of paper using the same outline. Attach additional sheets, if necessary)

19 Court and Name of District:

20 Docket Number:

21 Assigned Judge:

22 Disposition :

23 (For example, was the case
24 dismissed as frivolous or for
25 failure to state a claim? Was it
26 appealed? Is it still pending?)

23 Approximate filing date of lawsuit:

24 Approximate date of disposition:

Defendant's (continued)

Defendant's Name, Address and Phone Number	Sound Physicians (for Dr. Mary Vancleave) Attn: Administration 1123 Pacific Avenue Tacoma, WA 98402 (253) 682-1710
Defendant's Name, Address and Phone Number	Southlake Clinic Attn: Administration 4011 Talbot Rd S #500 Renton, WA 98055 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. Frank Thomas Talbot Professional Center 4011 Talbot Road S., Fifth Floor Renton, WA 98055 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. Richard Wall Medical Arts Center 4033 Talbot Road S., Suite 500 Renton, WA 98055 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. William Park Medical Arts Center 4033 Talbot Road S., Suite 500 Renton, WA 98055 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. Stefanie Nunez Medical Arts Center 4033 Talbot Road S., Suite 500 Renton, WA 98055 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. Suzanne Krell Newcastle Medical Pavilion 7203 129th Avenue Southeast, Suite 280 Newcastle, WA 98056 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. Fatime Goda Talbot Professional Center 4011 Talbot Road S., Suite 500 Renton, WA 98055 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. Wynne Chen Medical Arts Center 4033 Talbot Road S., Suite 500 Renton, WA 98055 (425) 251-5110
Defendant's Name, Address and Phone Number	Dr. Michael Hori Talbot Professional Center 4011 Talbot Road South, Suite 460 Renton, WA 98055 (425) 271-5020

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Statement of Claim

State here as briefly as possible the facts of your case. Describe how each defendant is involved, including dates, places, and other persons involved. **Do not give any legal arguments or cite any cases or statutes.** If you allege a number of related claims, number and set forth each claim in a separate paragraph. (Attach additional sheets if necessary.)

Please see the attached documentation and exhibit. This data was too lengthy to put in the space provided.

UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF WASHINGTON

The Estate of Mark David Turnage Jr.) Case No.: [Number]
)
 Plaintiff,) Estate of Mark David Turnage, Jr.
)
vs.)
)
Valley Medical Center, et. Al.)
)
 Defendant)
)

)

On November 9, 2010, Mark David Turnage, Jr. is at the Mount Rainier Kidney Center in Renton, Washington completing his dialysis session; I (Karie Fugate, his mother) call Mark at 7:13 pm prior to going to bed for the evening. Mark is not experiencing any symptoms. By 8:28 pm Mark calls back and is in pain (I am asleep in the back bedroom). Mark leaves a message on the answering machine "Mom, its Mark. On my right side up into my chest area the pain is real bad." He then tells the paramedic (who had arrived) that he has kidney failure and high blood pressure; Mark is transported to Valley Medical Center in Renton, Washington due to the proximity of the kidney center (right up the street) versus taking Mark to Swedish Medical Center where all of his providers are located.

I receive another call at 9:50 pm from Valley Medical Center that Mark is there, I'm still asleep and don't get the call but they leave a message on the answering machine. At 10:03 pm, Valley Medical Center calls again and I'm up at this time to receive the call. Mark is in the Emergency Room (ER). I arrive at Valley Medical Center about 10:30 pm. Mark was given something for pain. I ask Mark where it hurts (stomach area), what he ate (nothing) and a

1 few basic details. I check Mark's online banking records and receipts in his
2 wallet and confirm; he didn't eat anything today.

3 Blood work confirms pancreatitis. Dr. Arthur Sullivan, the ER doctor,
4 asks Mark multiple times if he is a heavy drinker or iv drug user because he
5 doesn't see any issues with his gallbladder from the ultrasound (gallstones
6 and alcohol are the top reason for getting pancreatitis) - Mark denies these
7 as he doesn't drink alcohol. Dr. Sullivan says Mark will be in hospital until
8 Saturday. The ER staff begin to prep Mark to bring him to his room #3727
9 around 2:30 am on 11/10/10. I leave the hospital and go home to sleep.

10 A Consent to Care and Treatment at Valley Medical Center form is signed
11 by 2 people at 21:45 saying that the patient was unable to sign because of
12 his condition. Documented from his arrival at 21:01 to 21:15 Mark is
13 answering questions about his pneumococcal, H1N1 and flu vaccines being up to
14 date, Mark was able to talk to the doctor and answer his questions, answer my
15 questions, the nurse charts that Mark is awake, alert, obeys commands,
16 oriented to person, place, time, events leading up to the ER visit today. The
17 Consent to Care form is signed 45 minutes before my arrival. I, as Mark's
18 parent, should have received this information, been given informed consent of
19 what to expect not only from the treatment for pancreatitis but also what we
20 can expect of Valley Medical Center, and I should have signed this form. Of
21 note is that Mark could have signed this the following day and had his
22 questions answered.

23 Also of note is that Dr. Sullivan puts on his ED Admit notes that Mark
24 has diabetes, he did not, that Mark has depression (but no medications are
25 listed for this) and that both parents are healthy per patient (Mark's father
26 is deceased - he died on 12/8/00 - Mark would have remembered as this was a
27 source for his depression along with losing his brother Aaron in a car
28 accident in 2009). Dr. Arthur Sullivan then hands off Mark's care to Dr.

1 Michael Mena, the hospitalist. Dr. Mena performs a history and physical but
2 notes that it is difficult due to Mark dozing off because of the medications
3 they have given him. Dr. Mena notes that Mark's nephrologist is Dr. (Robert)
4 Winrow of Swedish, (the home medications list is wrong), that the cause for
5 his renal failure is uncertain (even though Dr. Sullivan listed IgA
6 nephropathy) and that Dr. Mena would like to obtain records from Swedish. Dr.
7 Mena writes a request for obtaining Mark's Swedish medical records in the
8 History and Physical, the Focus Progress Notes and the Hospitalization order
9 set. Dr. Mena notes that no medications Mark is taking cause pancreatitis.
10 Dr. Mena then hands Mark's care over to Dr. Fatime Goda, another hospitalist.

11 Wednesday, 11/10/10 was uneventful in the hospital as Mark was
12 sleeping most of the day. Mark has a CT scan (with oral contrast) today that
13 notes gastro reflux disease. I have Desiree (the nurse) review Mark's
14 medication list with me. I find many errors and I ask her to correct them in
15 their computing system and to call Swedish to ensure we have the correct
16 doses listed. Dr. Goda does not review Dr. Mena's notes, follow-up on
17 obtaining Mark's medical records, or even place another order to obtain these
18 pertinent records from Swedish even though there are orders in place in the
19 Hospitalization order set; no one follows through to ensure these records are
20 obtained. Note: Mark has an ulcer on his toe and has been under the care of
21 another Swedish doctor; Valley Medication Center's wound care nurse orders
22 Swedish records on 11/15/10 at 13:00 and receive those records the same day
23 at 1:25 (25 minutes); other records from Swedish are faxed over on 11/19/10
24 at 9:36 am - these records are from previous procedures in 2009; the medical
25 records that should have been ordered on November 10th were actually received
26 at Valley Medical Center on January 6, 2011 at 4:43 and these were from
27 Mark's nephrologist visit with Dr. Robert Winrow (Swedish) on 9/27/10 (the
28

1 most current information). These records would have shown Valley Medical
2 Center and doctors that Mark's labs had been within the ranges for 6 months.

3 The home medications Mark was taking prior to going into Valley Medical
4 Center were Parnate (a MAO Inhibitor - 50 mg twice a day - date started
5 September 2007), Norvasc (10 mg once a day - date started July 2009),
6 Lisinopril (10 mg once a day - date started August 2006), Famotidine (20 mg
7 once a day - date started January 2006), Tricor (145 mg once a day - date
8 started July 2005), Gabapentin (900 mg twice a day on non-dialysis days; 900
9 mg / 1500 mg on dialysis days - date started January 2006), Sensipar (90 mg
10 once a day - date started September 2006), Triazolam (.25 mg as needed for
11 sleeping - date started October 2004). I find out later after a medical
12 record review that Mark's home medications were abruptly stopped (and Valley
13 Medical Center and the doctors have not contacted Swedish for his medication
14 list and doses; only records having to do with Mark's toe). The last time
15 Mark takes all of his home medications is on 11/8/10; on 11/9/10 Mark only
16 took is morning medications (Parnate and Gabapentin).

17 I arrive at the hospital on 11/11/10 about 9:45 am and Mark is now
18 delirious. They have given Mark Dilaudid (at 8:30 am). Desiree (the nurse)
19 says that she has been giving Mark Dilaudid every 2 hours because he is
20 being "aggressive." Mark cannot form sentences and can only say a single word
21 or two, he is continuously moaning, and doesn't want to stay in the bed. He
22 is now on a bed watch. He is saying things that do not make sense like "let's
23 end it now," etc. I ask Mark what's wrong, is it the drugs he says "yes". I
24 have Dr. Goda paged 2 times. Dr. Goda finally arrives and we discuss that
25 dialysis may get the Dilaudid out of his system; Mark might be having an
26 allergic reaction to the drugs. Dr. Goda mentions Mark being "aggressive" I
27 tell her I've never seen this in Mark before, it's almost like he lost his
28 mind. They even suggest giving Mark Benadryl.

1 Delirium is often caused by a disease process outside the brain, such
2 as infection (UTI, pneumonia) or drug effects, particularly anticholinergics
3 or other CNS depressants (benzodiazepines and opioids). Drug withdrawal is a
4 common cause of delirium. Medications including psychotropic medications,
5 opiates and benzodiazepines can cause delirium or worsen it.

6 Mark was going through classic drug withdrawal symptoms yet Valley
7 Medical Center and the doctors failed to diagnose and treat the underlying
8 condition. Long term use of Parnate (an MAO inhibitor) and abrupt
9 discontinuation can cause withdrawal symptoms of aggression, anxiety, balance
10 issues, blurred vision , brain zaps, concentration impairment, confusion,
11 constipation, crying spells, depersonalization, diarrhea, dizziness, electric
12 shock sensations, fatigue, flu-like symptoms, hallucinations, highly
13 emotional, impaired speech, insomnia, jumpy nerves, lack of coordination,
14 lethargy, nausea, nervousness, over-reacting to situations, paranoia, severe
15 internal restlessness (akathasia), stomach cramps, tremors, tinnitus (ear
16 ringing or buzzing), tingling sensations, worsened depression. Long term use
17 of Gabapentin (Neurontin) and abrupt discontinuation can cause insomnia,
18 restlessness, agitation, anxiety, disorientation, confusion, diaphoresis
19 (sweating), headaches, palpitations, hypertension, chest pain, and flu-like
20 symptoms. Literature states that Gabapentin should not be discontinued
21 abruptly after long term use. Abrupt or over rapid withdrawal may provoke a
22 withdrawal syndrome reminiscent to alcohol or benzodiazepine withdrawal.
23 Gradual reduction over a period of weeks or months helps minimize or prevents
24 the withdrawal syndrome. Long term use of Sensipar and abrupt discontinuation
25 can also cause withdrawal symptoms. Literature also states that if you have
26 been using Sensipar for long, never stop its use completely and suddenly.
27 Your doctor will tell you to first reduce its strength and quit this
28 medication.

1 The standard of care was not met for ordering Mark's medical records to
2 ensure Valley Medical Center and doctors had accurate data to ensure patient
3 safety. The standard of care was also not met on the discontinuation of these
4 medications. The standard of care was for Valley Medical Center and doctors
5 to obtain medical records stat for a patient that is being seen at a non-
6 Valley Medical Center entity (Swedish) particularly when the patient has
7 kidney disease and is on dialysis. Dr. Fatime Goda failed to do a job that is
8 expected for patient safety and care (especially as a hospitalist) - to get
9 the medical records to properly manage the patient's care; after all these
10 records were previously requested and assumed ordered by the hospitalist that
11 handed Mark's care over to Dr. Goda. Also, Valley Medical Center Renal Group
12 failed to contact Dr. Robert Winrow (Swedish) to discuss a kidney dialysis
13 patient's previous and continuing care; and also discontinued the Gabapentin
14 and Sensipar abruptly (because they felt that it can cause pancreatitis - the
15 gastrointestinal doctor [GI] should have been responsible for the
16 discontinuance of these but wasn't involved in Mark's care until 11/12/10).
17 Valley Medical Center, the pharmacy and doctors still did not see that
18 Parnate was added to the computing system per my request (and my request for
19 them to contact Swedish for the proper dose) and that Parnate was abruptly
20 discontinued when Mark was admitted to Valley Medical Center (they failed to
21 review the computing system for drug changes). The Valley Medical Center
22 pharmacy should have reviewed the computing system and noted that Parnate (a
23 MAO inhibitor) has specific warnings for certain drug combinations that can
24 cause toxic drug interactions (i.e. Do not use Fentanyl if you have used an
25 MAO inhibitor in the last 14 days [which Mark will soon be given]; avoid
26 taking Morphine if you have used an MAO inhibitor within the past 14 days
27 [Mark was given Morphine]) and that abrupt discontinuation of Parnate,
28 Gabapentin and Sensipar can cause withdrawal symptoms. The drug combinations

1 given to Mark caused the toxic side effects the staff were noting in Focus
2 Notes (respiratory depression, decreased blood pressure; flu like symptoms;
3 confusion, agitated, combative, anxious, delirious, etc.) and caused Mark to
4 exhibit septic-like symptoms.

5 It's still 11/11/10 and dialysis can't be started because Mark's
6 fistulas are not working now; apparently the sedatives given to him caused
7 his blood pressure to drop resulting in the loss of his fistulas; they need
8 to insert another access line. I leave the hospital to pick my husband,
9 Wayne, up from the airport. I talk to the hospital at 7:45 pm and find out
10 that Mark is now in room 403 Intensive Care Unit (ICU) because the 3rd floor
11 nurses can't handle him. They have to put in a central line for antibiotics.
12 My husband and I arrive back at Valley Medical Center about 8:00 pm. Mark is
13 very delirious at this time and Wayne has to hold him to the bed. They end up
14 strapping Mark down to the bed with restraints. Mark's color is very yellow.
15 Mark thinks his name is "Calvin" and yells for us to "cut him loose and he
16 will tell us where she is" and "I need to run to the forest it's the only
17 place I'm safe." We should have listened to him. We leave around 11:30 pm; by
18 1:30 am on 11/12/10 Dr. Mary Vancleave, another hospitalist, calls the house
19 and says they have heavily sedated Mark (with Fentanyl and Versed) because he
20 was being aggressive. They had to put him on a respirator (intubate him)
21 because of the sedation; Mark's breathing was very shallow. Dr. Vancleave
22 asks me what Mark's wishes are and do I have a power of attorney. Remember
23 with drug withdrawal and delirium, medications including psychotropic
24 medications, opiates and benzodiazepines can cause delirium or worsen it;
25 Mark had also been taking a MAO inhibitor for years. Dr. Vancleave should
26 have looked at the hospitalist notes and also requested records from Swedish
27 that contained what drugs Mark had been taking. Dr. Vancleave does however
28 note that she is questioning withdrawal from Gabapentin.

1 11/12/10 is the first visit with a gastrointestinal doctor (GI) - Dr.
2 Daniel O'Neill. In his consult, Dr. O'Neill states that the patient has been
3 on long-term Parnate (MAO inhibitor), gabapentin, etc. Somehow, Dr. O'Neil
4 has access to Mark's previous medications as he does mention "long-term."

5 Mark is now heavily sedated, intubated, restrained to the hospital bed
6 with ankle and wrist straps and going through medication withdrawal and toxic
7 drug interactions. Dr. Vancleave tells us the sedation is required for Mark's
8 pain, however, nursing notes say that pain is assumed. The intensivist notes
9 say that Mark is well sedated (too well) and that sedation may be a part of
10 the persistent pressor (for blood pressure) requirement and fever might be
11 related. On 11/13/10, Mark is brought to have a CT Scan (with oral contrast -
12 note that the 11/10/10 CT Scan Valley documented Mark having gastro reflux
13 disease). There are no notes in Mark's Valley Medical Center medical records
14 that start what actually occurred but the results of the CT scan document
15 that Mark (vomited and) aspirated the contrast agent, while heavily sedated,
16 intubated, strapped to the bed and unable to communicate to the person
17 performing the CT scan. If Valley Medical Center had a process for aspiration
18 precautions for vulnerable patients it did not work. I believe a process
19 should be in place.

20 By 11/14/10, Shelly (the nurse) mentions to me that a sputum (lung
21 secretions) culture is now growing organisms; by 11/17/10 Methicillin-
22 resistant Staphylococcus aureus (MRSA) and Enterobacter Cloacae are confirmed
23 growing in Mark's sputum. We now pursue having Mark transferred to Swedish
24 Medical Center in Seattle, Washington. Dr. Suzanne Krell, the intensivist of
25 the day, tells me that Medicare and my insurance will not pay to transfer
26 Mark because that is not a medical necessity. Valley Medical Center can
27 perform almost any procedure. We agree to pay for the transportation costs;
28 Dr. Krell says that Mark is not stable enough to transfer so there would be

1 risks. Dr. Krell states that Mark now has multi-organ failure (lungs
2 [aspiration and bacteria], blood pressure [sedation], brain [drug
3 withdrawal], and pancreas [pancreatitis]) - "Sepsis." Mark will be in the
4 hospital for 1 to 2 weeks. I show Dr. Krell a Cytochrome P450 2C9 genetic
5 study Mark had done at Swedish with a letter attached from Dr. Robert Olsen
6 (Swedish) stating medications Mark should be aware of and avoid because he is
7 a 2C9 poor metabolizer. Dr. Krell looks at it and hands it back to me. Mark
8 is now having fevers that are going above 103 degrees. Dr. Krell leaves
9 Mark's room and a few moments later a nurse comes in and wants phone numbers
10 from the Swedish doctors I've been talking to.

11 11/19/10 is the day the respirator tubing fails. Mark was very alert
12 today and able to squeeze Jane's (the nurse) hand. At 3:08 pm (Jane is at
13 lunch) and Mark's breathing became very labored and it he was making a very
14 strange sound. I go out in the hall and get Jane's back up, Tony, and tell
15 her the IV pump and respirator are both alarming, and something is wrong with
16 Mark's breathing and the equipment. Tony comes in the room and tries to
17 suction out Mark's lungs. I ask Tony to call respiratory, she does and says
18 he (Dan) is busy writing up a report with someone. I tell her to call him
19 back or give me the number to call. Tony yells at Mark "Mark" "You are over
20 reacting" about 5 times, then zaps Mark with 2 bolus of sedatives. The sound
21 and labored breathing do not stop, Mark is now unconscious. I tell Tony to
22 call respiratory back, she does and Dan arrives. After inspection Dan finds
23 out that there is a crack in one of the respirator tubes; he puts tape on it.
24 I ask Tony why Mark is unconscious, Tony says that the first bolus of
25 sedatives she gave him didn't work, so she gave him another. A little while
26 later, Mark starts struggling again. This time I go down the hall to see if I
27 can find Dan versus getting Tony involved. I see Jane coming back from lunch
28 and ask her to please come, something is very wrong with Mark and his

1 breathing." She does. Jane calls Dan, he arrives and does another inspection.
2 I leave the room shaken and by the time I get back Dr. Stefanie Nunez and 4
3 or 5 other people are with Mark getting ready to pull out the respirator and
4 re-intubate him. Apparently the balloon type of device that holds it in place
5 and keeps air from seeping out has failed. They paralyze Mark for 20 minutes
6 to get this placed. Afterwards, we discuss with Dr. Nunez that we have lost
7 all faith in the doctors and Valley and want Mark transferred to Swedish
8 Medical Center.

9 The next day, 11/20/10, I show Dr. Stefanie Nunez the Cytochrome P450
10 2C9 genetic study Mark had done at Swedish with Dr. Robert Olsen's (Swedish)
11 letter stating medications Mark should be aware of and avoid because he is a
12 2C9 poor metabolizer. Dr. Nunez reads it and hands it back to me.

13 By 11/21/10 the latest tracheal aspirate culture grows MRSA and
14 Burkholderia cepacia. Per a discussion with a clinical microbiologist,
15 Burkholderia is not found in healthy people and is a very resistant organism.
16 It is very obvious that Mark acquired this through the intubation procedure
17 (lack of sterile technique and/or the equipment). I am not told about the
18 Burkholderia until 12/4/10 even though Valley Medical Center and doctors had
19 the data. Dr. Mary Vancleave does state in her Interim Summary that
20 Burkholderia is sensitive to Ceftazidime. No orders for Ceftazidime exist in
21 Mark's medical records until 1/11/11 (to discontinue it - by Dr. Krell), then
22 on 1/12/11 (to start it back up - by Dr. Michael Hori), then an order
23 clarification, another order on 1/14/11 (by Dr. Hori), then what appears to
24 be a clarification of the order. Valley Medical Center is not certain if the
25 nurse gave it or forgot to input it into the Medical Administration Record
26 (MAR), but "they feel Mark's account was undercharged." Had Dr. Vancleave
27 done the job expected of a hospitalist she would have ordered the Ceftazidime
28 at the time she discovered Burkholderia was susceptible.

1 On 11/24/10 Dr. William Park says Mark is stable enough to transfer to
2 Swedish; I am told that Dr. Vancleave and Michelle Bohl (Social Worker) have
3 been working this. We are told on 11/26/10 that Swedish rejects Mark's
4 transfer. Per an interview of Valley Medical Center Risk Management Officer,
5 Steve Haton, "there was a Valley letter and a Swedish letter and the bottom
6 line is the level of care wasn't going to change regardless of whether the
7 patient, Mark Turnage, was transferred or not. I don't think insurance had a
8 lot to do with it." Per Michelle Bohl, Mark had run through the allotted time
9 allowed for pancreatitis per Medicare and his DRG has been spent. Valley will
10 only receive ~\$100K, a payment from Regence and \$0 from Medicade (Medicade
11 says all has been paid when Regence pays). The rest (~\$200K) will have to be
12 written off by Valley Medical Center. Because Swedish would not make any
13 revenue, they will not accept Mark (per their financial officer). Per Dr.
14 John Vassall, the Chief Medical Officer of Swedish, "Our review has not
15 identified any information or documentation that indicates Swedish was
16 contacted regarding a request to transfer your son to our facility." Also on
17 this day I show Dr. Michael Hori the Cytochrome P450 2C9 genetic study Mark
18 had done at Swedish with Dr. Robert Olsen's (Swedish) letter, Dr. Hori states
19 these medications have to do with psychiatric drugs. Dr. Hori hands the study
20 back to me.

21 On 11/25/10 Dr. Duane Carlson, GI, orders an ultrasound of Mark's
22 abdomen. The results are that the gallbladder is now seen to be largely full
23 of sludge with one or two tiny mobile dependent gallstones seen (the source
24 of the pancreatitis - these gallstones were also present at autopsy). It also
25 mentions that the common duct is actually less prominent than on the earlier
26 ultrasound. Dr. Frank Thomas, GI, is the GI hand-off for dates 11/26/10
27 through 11/27/10 and does not review these records. It is not the standard of
28 care for a doctor to not know what his GI team ordered, to not check the

1 results of those, and to not relay that critical medical information back to
2 the entire medical team. Hence, this information was not relayed to Mark's
3 care team until I located it after receiving some of Mark's medical records
4 on 1/7/11 (I was told to get a lawyer to obtain Mark's records).

5 On 11/30/10 I am on my way home and I think about the 2C9 genetic test
6 and the Fluconozole the nurse just started. I race home, verify, then call
7 the nurse and ask her to stop the Fluconozole and call the doctor. She says
8 she will and calls Dr. Richard Wall. According to the Medication
9 Administration Record (MAR) Mark is also given the Fluconozole on 12/1/10. In
10 the doctor daily rounds on 12/1/10, Dr. Richard Wall states that the 2C9
11 genetic study has to do with immunosupresion and transplant. The Valley
12 Medical Center pharmacy calls me twice today to obtain the Swedish records
13 because the 2C9 study is very significant in how your liver metabolizes
14 drugs. It is not the standard of care to give doctors the 2C9 study and for
15 them to dismiss it because they do not understand it; they should have given
16 it to the pharmacy at this point. What is also very significant about this
17 study is that Valley Medical Center doctors and pharmacy continued to
18 prescribe medications that Mark's liver could not metabolize causing his
19 liver failure in the end (note: the pharmacy does not have the final say in
20 which drugs are prescribed for the patient, the doctor in charge does).

21 12/2/10 is the day that Dr. C. Gabriel Alperovich removes Mark's
22 respirator equipment and transitions him to a tracheotomy (Dr. Richard Wall
23 assists). After the tracheotomy Dr. Alperovich inserts a peg-tube into Mark's
24 stomach for nutrition. By 12/4/10 a new bacteria is identified in Mark's
25 lungs, this time Pseudomonas aeruginosa; by 12/9/10 Pseudomonas and
26 Burkholderia are growing in the peg-tube incision site. This is not the
27 standard of care for a doctor to not re-glove between procedures (especially
28 when the patient already had acquired the Burkholderia infection in his

1 lungs) and then transfer the bacteria from one site to the other ((cross-
2 contamination and also introduce a new bacteria). These procedures were done
3 in this order and according to Dr. Alperovich's records. By 12/14/10 the
4 Pseudomonas is identified in Mark's stool. Cross-contamination is preventable
5 and these procedures do not meet the standard of care.

6 By 12/5/10 Mark has Stage 2 bedsores (which are preventable and does
7 not meet the standard of care). According to the patient family education
8 worksheet, Mark is to be turned each 2 hours (this is noted on 11/30/10 - 19
9 days after being restrained with sedatives and straps). Mark is restrained to
10 the bed from 11/11/10 to 11/30/10; then again on 12/3/10 to 12/11/10. Non-
11 violent restraint orders are to be completed each day, however, 11/13/10 is
12 missing. Also noted is that on the restraint nursing assessment tool and plan
13 of care worksheet (which is to be filled out each 2 hours by the nurse) that
14 11/27/10 8:00 through 18:00 those records are not logged into the worksheet.
15 This does not meet the standard of care for a sedated, restrained patient.
16 Had Mark been turned each 2 hours instead of each 4+ hours he would not have
17 gotten the bedsores. Bedsores are preventable; this does not meet the
18 standard of care.

19 On 12/10/10 I am getting ready to leave the hospital for the day. I
20 turn around to look at Mark and he is having what appears to be a seizure. I
21 yell for Debbie's (the nurse) help. The seizure like event only lasts a
22 couple of seconds. I am told that Mark is septic once again and but after a
23 review of Mark's medical records on 1/9/14 metabolic acidosis is mentioned (a
24 disruption of the body's acid/base balance, can indicate a more serious
25 problem with a major organ like the liver, heart, or kidneys. It can also be
26 one of the first signs of drug overdose or poisoning). The Valley Medical
27 Center neurologist is called, Dr. Joy Zhao. Dr. Zhao suspects severe
28 metabolic encephalopathy (temporary or permanent damage to the brain due to

1 lack of glucose, oxygen or other metabolic agent, or organ dysfunction. Most
2 cases occur when the liver cannot act normally to remove toxins from the
3 bloodstream during an acute illness, but it can also be caused by a toxic
4 overdose, or other systemic disease) versus seizure. On 12/11/10 the nurse
5 documents Mark's pupils being different sizes (Anisocoria is a condition
6 where the pupil of one eye differs in size from the pupil of the other. The
7 most common causes include seizure). None of the doctors think Mark had a
8 seizure. I am told after 2 days of monitoring that Mark might be brain dead.
9 On this same day Dr. Michael Hori stops antibiotics. Dr. Hori also mentions
10 that Mark's liver issues are not medication related. I discuss my concerns
11 about the antibiotics being discontinued when Pseudomonas was just found; Dr.
12 Frank Fung has the antibiotics restarted.

13 12/14/10 Dr. Daniel O'Neill orders a stool culture and 1) never reviews
14 the report, 2) never discusses the results of those with his peers, 3) never
15 discusses the results of those with me. Focus notes have no mention of
16 Pseudomonas in Mark's stool. This is not the standard of care for a doctor to
17 order lab work and not follow-up or coordinate those results.

18 There were many other issues with rectal tubes not producing stool for
19 days then the entire equipment "blowing out" of Mark's rectum, nasal
20 temperature probes being put into Mark's lung, finding foreign object debris
21 in Mark's bed (including blood filled syringes), Mark being left in a soiled
22 gown/bed and too many other events to list here. On Friday 12/17/10 we sign a
23 do not resuscitate order.

24 On 12/19/10 Cheryl (the nurse) mentions to Dr. Amy Morris that the same
25 fluid that is coming out of Mark's lungs appears to be coming out of his
26 stomach Peg tube. I ask Dr. Morris about this and she isn't concerned. I ask
27 Cheryl if she could interpret what the doctor said about this and she said
28 Dr. Morris really didn't explain it well.

1 12/20/10 we are told Mark's prognosis isn't good. He isn't responding
2 to anything. Mark's liver is looking better (2C9 contraindications will be
3 discussed later). Dr. Richard Wall says Mark is septic again (blood pressure
4 and fever are the usually the indicators) and that he is having an
5 inflammatory response. In our group doctor meeting today Dr. Wall uses an
6 analogy of car repairs. Dr. Wall says "you wouldn't want an expert working on
7 your tires or changing your windshield wipers would you?" We remind Dr. Wall
8 that we are not trying to fix the windshield wipers or the tires - WE ARE
9 TRYING TO FIX THE ENTIRE CAR! Dr. Wall says the intensivist will be the
10 "Quarterback" for the team of doctors. Dr. Wall explains to us that there is
11 nothing else they can do for Mark and we agree at to put Mark on comfort care
12 12/21/10 at 6:00 pm. We make funeral arrangements this day.

13 12/21/10 at about 1:30 pm Mark wakes up and is responsive! Mark is
14 licking his lips on command and answering questions. Mark wasn't brain dead
15 after all.

16 Over the next few days we see the impact from the bacterial infections.
17 Mark is shaky and there is a lot of puss coming out of his tracheotomy; foam
18 is coming out of Mark's Peg tube. Mark vomits up a whiteish color and a lot
19 of it. Later there is thick white mucous coming out of Mark's Peg tube and no
20 one seems concerned other than me. We also notice over the next couple of
21 days the impacts from the contraindicated medications due to gallstones,
22 pancreatitis and Mark being a 2C9 poor metabolizer.

23 Drugs that can cause Pancreatitis - Gallstones / Contraindicated.
24 Fenofibrate (history: 7/27/05 to 11/8/10), Gemfibrozil (12/5/10 to 1/15/11),
25 Metronidazole (11/23/10 to 11/27/10; 12/12/10 to 12/16/10; 1/7/11 to
26 1/16/11), Quetiapine (12/29/10 to 1/14/11), Ondansetron (11/9/10 to 11/10/10,
27 11/19/10), Pantoprazole (11/10/10 to 11/16/10), Propofol (12/2/10)

28

1 Drugs that a 2C9 poor metabolizer should avoid (liver cannot
2 metabolize). Gemfibrozil (12/5/10 to 1/15/11), Metronidazole (11/23/10 to
3 11/27/10; 12/12/10 to 12/16/10; 1/7/11 to 1/16/11), Fluconazole (11/30/10 to
4 12/1/10). Note: At autopsy Mark's liver was greenish black color.

5 Drugs that cause elevated liver enzymes. Gemfibrozil (also a 2C9
6 inhibitor) 12/5/10 - 1/15/11, Dexamethasone (also a 2C9 inducer) 12/26/10 -
7 1/7/11, Metronidazole (also a 2C9 inhibitor) 11/23/10 - 11/27/10, 12/12/10 -
8 12/16/10, 1/7/11 - 1/16/11.

9 12/25/10 Dr. William Park mentions that the pancreatitis seems to be in
10 control right now and that the Pseudomonas in Mark's lungs is a real problem.
11 Pseudomonas can actually liquefy his lungs. Dr. Park does a bronchoscopy
12 today to check the placement of the tracheotomy and look at and clean the
13 inside of Mark's lungs. Later Dr. Park says he will order an older
14 antibiotic. I cannot locate the order as it is not in the medical records but
15 Dexamethasone is ordered and started on 12/26/10. Dexamethasone is a steroid
16 (used for inflammation, immunosuppression, etc.) and can suppress the immune
17 system, which could lead to an increased risk of infection or make infections
18 worse. On this day Mark's white blood cell (WBC) count is 16.3 (range is
19 between 4 and 11); by 1/7/11 when Dexamethasone is stopped Mark's WBC is
20 55.4. WBC continues to increase to 89.3 on 1/14/11.

21 From 12/20/10 to 12/29/10 Mark receives no visits from the GI team of
22 doctors even though he has severe pancreatitis.

23 By 12/30/10 Dr. Suzanne Krell says that pancreatitis / pneumonia are
24 still the conditions Mark is battling. Mark's Bilirubin is up to 17 (Mark's
25 eyes are now yellow again); Bun is 118 (to be expected with kidney disease)
26 and liver enzymes are now 4 to 8 times higher than yesterday. Dr. Krell feels
27 this has something to do with his confusion. Fever this morning is 101.4.

28

1 On 12/31/10 Dr. Suzanne Krell tells me that Mark's liver is starting to
2 fail. On this same day, Dr. Vilma Quijada comes by and says that Mark's liver
3 isn't good. Dr. Quijada says the only way to fix something like this is for a
4 liver transplant. Dr. Quijada mentions getting all the doctors together to
5 discuss a plan (because his labs are all over the place with the new
6 antibiotics and changes). Dr. Frank Thomas, GI, stops by and says that Mark
7 is getting better. Dr. Thomas is stopping TPN because he feels this is
8 causing the liver enzymes to be elevated (Dexamethasone and others had the
9 potential to cause this); says that Mark will be fine without nutrition for a
10 couple of days until they place the new naso duodenal G-tube that will go
11 into his stomach and past the pancreas (into the small intestine). On this
12 same day, Dr. Thomas By 1/2/11 Dr. Thomas stops by and says Mark's liver
13 tests/enzymes are getting worse. He wants a CT of the liver done to look at
14 the 2 blood vessels of the liver. Because of the elevated enzymes he is
15 wondering if there is a clot in one of them. I think it is the
16 drugs/antibiotics.

17 01/04/11 When I get back to Mark's room he has vomited (~9:30 am) and
18 Mabel, the nurse, is nowhere to be found. Mark's tracheotomy patch is moved
19 to the side and the respirator machine is alarming constantly. I had asked
20 Mabel about 7:00 am to get some washcloths and towels so I could clean Mark's
21 face (these still aren't in the room at 9:30). I have to push the nurse alarm
22 on the remote and about 15 minutes later she arrives (in an ICU). By then I
23 have tried to clean up the vomit, and the vomit that went down the
24 tracheotomy as best I could. Mabel finally arrives and says "she has to go
25 and take care of the next door patient's iv's before she can get back." I ask
26 her to call respiratory (because of the vomit I see in the tracheotomy tube)
27 ~ she says they won't be here until 10:30. I clean up Mark the best I can.
28 The respirator continues to alarm. I tell Mabel something is wrong, she says

1 Mark has to stop moving. I tell Mabel that he is in pain and if she was in
2 that much pain she would be moving too. I also tell Mabel that I disagree
3 with her, the respiratory alarms are something that just happened after Mark
4 vomited. Mabel goes and gets Dr. William Park (I assume) and he comes in and
5 sees that the tracheotomy is in a poor position causing it to continuously
6 alarm. Now the alarms stop, even though Mark is still moving around. Another
7 issue is Mark's bed ~ an air mattress that needs to be plugged in. This was
8 obtained because of Mark's bedsores. Mark is brought back to the room today
9 from having a liver biopsy, x-ray, and feeding G-tube placement. Instead of
10 plugging in and turning on the air mattress bed (which is like laying on the
11 ground or concret), the nurse goes and starts putting up equipment first.

12 1/7/11 I arrive at the hospital about 7:00 am and find out that that
13 Mark's heart stopped about 5:18 am but it recovered. Michele Bohl, Social
14 Worker, tells me I should tell Mark it is ok for him to "go" (die) ~ there
15 isn't anything else they can do for him. She tells me Mark is holding on for
16 me. I make a formal request for Mark's records. The nurse says I have to go
17 to administration. I go to administration and they tell me to get a lawyer; I
18 tell the nurses and I call one. Valley Medical Center then turns over some of
19 Mark's medical records (this is when I find out Mark aspirated oral contrast
20 and that Mark has 2 gallstones). Dr Daniel O'Neil, GI, tells me the liver
21 biopsy shows blockage of the ducts which is most likely caused by
22 medications. He will work with the doctors to see which ones they can
23 discontinue. There are no orders in the medical records that state which
24 drugs Dr. O'Neil discontinues. Note: There are 2599 entries of medications
25 given to Mark per the hospital bill.

26 Also on this day, Debbie and I go to turn Mark so the wound nurse can
27 change the bandages for Mark's bedsores. Mark is turned on his side for about
28 5 minutes and by the time we turn him back over there is bile all over the

1 blue sling that is beneath him and the bandage (Tegaderm-like) is literally
2 full of fluid. I ask Debbie to page Dr. Daniel O'Neill, GI; she does. I ask
3 her to talk to Dr. O'Neill first and then I would like to talk to him. He
4 calls and talks to Debbie but says he is too busy to talk to me. Mark is now
5 in pain. I also note that there is a large red patchy area around the G-tube
6 incision and bile is oozing, bubbling and a lot of fluid is coming out of the
7 incision. Dr. O'Neill says this is normal. A tracheotomy sample is obtained
8 today; I find out on 1/9/14 that the Pseudomonas is gone but the Burkholderia
9 is still present. This was never mentioned to me. Also today Dr. Michael Hori
10 comes in and says he has never seen a person on "4" pressers (for blood
11 pressure) in his career. I ask nurse later if it's 3 or 4 and Jed, the nurse,
12 confirms it's 3.

13 At 10:30 pm I receive a call from Dr. Amy Morris that Mark's heart
14 stopped beating around 9:00 to 9:30 pm for 1 minute (asystole). Sue is the
15 nurse and gave him Atropene, Epinephrine and Narcan. Apparently Mark was
16 trying to communicate, he was on his left side, the vent alarms went off, his
17 heart went into Brady. We also discuss my concerns of the bile coming out of
18 the G-tube incision.

19 1/9/11 Mark is in a lot of pain now and is belching massively. His G-
20 tube incision is still oozing bile and it drips down Mark's side. Jed, the
21 nurse, goes to change the bandage on Mark's G-tube and I see a light green
22 bubbling, oozing fluid. At his same time I see doctors Daniel O'Neill and Amy
23 Morris in the hall and ask them to come in here and look. Dr. Morris is too
24 busy; Dr. O'Neil comes in (without gowning and putting on gloves) and removes
25 the bandage. He looks very concerned. He says this is common and moves the G-
26 tube around a bit; he may have to consider a pancreatic drain. Mark is in a
27 lot of pain even after Jed, the nurse, gave him the Fentanyl. Dr. O'Neill
28 says that to replace that G-tube Mark would have to be moved to some type of

1 acute place. Dr. O'Neill suggests putting the suction (instead of gravity) on
2 the stomach fluid drain. Jed does. I mention Mark's abdomen and thighs
3 looking like they will burst; Dr. O'Neill says he will talk to Dr. Morris and
4 see if there are areas that can be drained in Mark's abdomen. I ask Dr.
5 O'Neil where all the drainage is coming from and I get no answer. A little
6 later Mark starts foaming at the mouth, burping quite a bit. I now hear the
7 suction, gurgling coming out of the incision. He keeps rubbing his stomach
8 and is in a lot of pain. I note that at 11:30 pm that Mark's heart rate is
9 into the 50's and WBC is now 62.8.

10 1/10/11 Mark has been belching all day long; and has massive gas. The
11 brand new rectal tube inserted early this morning fails and feces on bed is
12 gurgling (like a geyser 2 to 3 inches up from the bed) from all the gas; the
13 stool collection bag is literally full of gas. I ask Mary (the nurse) to page
14 Dr. Christopher DiRe, GI, on call. Dr. DiRe shows up at ~12:30 pm and I tell
15 him about the foaming at the mouth, massive gas, belching, stool collection
16 bag being full of gas, the gurgling feces and about the G-tube incision
17 discharge gurgling (you can hear air in there). DiRe says this all has to do
18 with the complex nature of fluid collection and that it is possible that the
19 stomach fluid got into his abdomen. I told him this all started right after
20 the bronchoscopy. I ask about the stomach fluid sample that Jed took the day
21 before and DiRe says it has amylase in it. I also mention gallbladder stones
22 (Dr. DiRe has no idea that gallstones showed up back in November). I show him
23 the lab work (and he looks it up on the computer). Mary (the nurse) also
24 swabs the G-tube incision for culture (turns out to be Pseudomonas and
25 Burkholderia).

26 By 1/11/11 the G-tube incision continues to leak and is now brown and
27 foul smelling (per Cheryl the nurse). I also notice that a lot of the fluid
28 retention in the stomach is going down; however his thighs have double in

1 size. On 1/12/11 Dr. Suzanne Krell comes by later and says the bacteria on
2 the G-tube swab test is Pseudomonas and it is resistant to all antibiotics
3 tried at Valley Medical Center. By this day Dr. Suzanne Krell, intensivist,
4 should have known that the Pseudomonas was no longer in the tracheal aspirate
5 - after all it's her job. Dr. Krell says Mark will die of sepsis, not GI
6 issues. I ask about the liver biopsy, and she hasn't seen it come back. We
7 request a 2nd opinion because of the oozing and foaming bile coming out of
8 Mark's G-tube incision and the burping and massive gas, and tell Dr. Suzanne
9 Krell, et. al., this would be a third party unbiased opinion. We give them
10 Dr. Robert Driscoll's card from Swedish. We are turned down for a second
11 opinion as Dr. Driscoll doesn't want to get involved.

12 In our last family meeting with the doctors, 1/14/11, we have several
13 questions to ask them as we know that Mark will not live through all this. We
14 ask where the MRSA, Enterobacter, Burkholderia and Pseudomonas came from. We
15 are told that Burkholderia and Pseudomonas live in healthcare settings (and
16 that Pseudomonas is common) but when we push for more info, Dr. Michael Hori
17 tells us he believes that Mark had these bacteria in his lungs (got it in
18 Nevada back in 1999 or earlier) and had them when he arrived at Valley
19 Medical Center. Dr. Wynne Chen does not speak up as on 12/25/10 he had a call
20 from the Valley Medical Center lab because another patient had acquired the
21 Burkholderia and Pseudomonas. Dr. Chen calls the lab back and never says a
22 word about what happened - the nurse documents that it occurred. We are also
23 told that Mark went through only 2 septic events when in fact there was only
24 one. The first event was medication withdrawal, Valley claims this was an
25 inflammation event from the pancreatitis; no sepsis. The second event was
26 sepsis caused by Mark's lungs; Mark had metabolic acidosis and a seizure. The
27 last event just occurred and it was evident that the bacteria were the cause.
28

I go over what happened on 1/7/11 (G-tube incision leakage to the foaming of the mouth, massive gas, belching and the rectal tube bag being full of gas). Michele Bohl, Social Worker, re-asks my question pointing to this all being caused by the nutrition (and why it was stopped). Dr. Duane Carlson says no, that would not have caused those symptoms and he begins to explain that a bacteria population could have caused this (as the bacteria eat they produce gas). We have no idea that the Pseudomonas is gone from Mark's his lungs, maybe the antibiotics would have killed the Burkholderia and Pseudomonas in his gastrointestinal track. Of note is that Burkholderia was sensitive to Ceftazidime initially per Dr. Mary Vancleave (stated in her Interim Summary) and that Burkholderia is sensitive to Ceftazidime. No orders for Ceftazidime exist in Mark's medical records until 1/11/11 (to discontinue it - by Dr. Suzanne Krell), then on 1/12/11 (to start it back up - by Dr. Michael Hori), then an order clarification, another order on 1/14/11 (by Dr. Hori), then what appears to be a clarification of the order. Valley Medical Center is not certain if the nurse gave it or forgot to input it into the Medical Administration Record (MAR), but they feel Mark's account was undercharged.

Another question we have for them in this meeting is why they didn't follow the University of Washington (UW) recommended antibiotic of Ticarcillin/Clavulanic Acid as it was susceptible in 64 Pseudomonas and 64 intermediate Burkholderia (one of the nurses secretly gave us a copy of the UW results). Dr. Michael Hori says that he decided to use a "newer" drug versus using the older penicillin. I strenuously inserted "as a mother I would have prescribed what was recommended."

Wayne, my husband, and Bob Chapman, nursing supervisor get into a discussion of what a 2nd opinion versus a consult are: a second opinion is an unbiased third party looking at data and making their own opinion of Mark. A

1 second opinion is a visit to a physician other than the one a patient has
2 been seeing in order to get a differing point-of-view. Second opinions may be
3 sought by a patient under the following circumstances: the patient believes
4 they have a condition that physician fails to diagnose. A consultant means
5 "to discuss."

6 It is suggested that Mark be put on comfort care again and we tell them
7 we have been here before (on 12/21/10 when Mark woke up). This time we know
8 Mark will no live through all this. The Valley team begins to explain how
9 they will remove all equipment and let Mark pass "naturally" I disagree and
10 say they will keep the respirator and settings the same, all equipment
11 (lines) will stay in place for autopsy. They begin talking about the drugs
12 they will use.

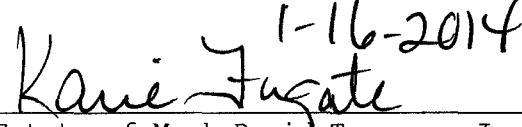
13 We ask what will the death certificate will say and are told 1) severe
14 pancreatitis 2) severe multi-antibiotic resistant bacteria. The death
15 certificate says 1) multi-drug resistant Pseudomonas and Burkholderia
16 pneumonia for 64 days (note the Pseudomonas was gone on the 1/9/11 culture),
17 2) severe pancreatitis, sepsis for 68 days.

18 1/16/11 Mark is put on comfort care. About 8:30 am Cheryl begins slowly
19 taking off the supportive meds and shutting down the CVVH DF dialysis
20 machine. Mark dies at 11:50 am with all of us by his side. At least we were
21 able to have his black lab come see him before he passed away.

22 The root cause analysis is had Valley Medical Center and doctors
23 ordered Mark's medical and prescription records from Swedish on the first day
24 none of this would have occurred. There was no accountability and no check
25 and balance system in place. When this system failed, the doctors and care
26 team should have ensured that at least their hand-offs were occurring and
27 that communication and coordination for Mark's well-being and safety came
28 first. This too failed. There were too many silos for practicing medicine

1 within their own realms of responsibility (silos) and no consideration for
2 the patient. My son suffered and died an awful death because of all of this.

3 Dated this [day] of [Month], [year]
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The Estate of Mark David Turnage, Jr.
Karie Fugate, Personal Representative

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1 **Relief**

2 State briefly exactly what you want the court to do for you. Make no legal arguments. Cite no
cases or statutes.

3 Valley Medical Center and doctors provide payment in full of Funeral and related expenses \$15,000.00.

4 Valley Medical Center and doctors provide payment in full of Mark David Turnage, Jr.'s debts \$10,994.68.

5 Valley Medical Center and doctors provide payment in full for Mark David Turnage's suffering and untimely death
\$800,000.00.

6 Valley Medical Center and doctors reimburse Medicare \$324,527.68 and Regence Blue Shield \$11,301.14.

7 Valley Medical Center and doctors complete a certified Root Cause Analysis training program for all disciplines.
This training will benefit all in the event errors occur; disclosure is your friend in repairing broken processes.

8 Valley Medical Center develop a Healthcare Acquired Infection Control System that meets the intent of current
Federal laws and are accountable for those results. After development of the process and system, show objective
evidence the new system is working.

9 Valley Medical Center and doctors develop a tip sheet and/or process that applies across all disciplines for the
ordering of patient medical records that includes a validation step to ensure records of current and accurate
patient data including prescriptions are received in a timely manner. Show objective evidence the new system is
working.

10 Ensure the pharmacy has the appropriate authority to stop potentially life threatening medications from being
prescribed. Show objective evidence the new system is working.

11 Set up a position titled Patient Project Manager (PPM) for complex patient conditions and ensure patient safety.
Allow the PPM the authority to coordinate patient care (prescriptions, records, orders, lab work, tests,
correspondence, etc.). Allow the PPM the authority to override conflicts that can occur with the contracted staff,
pharmacy, etc.

12 Schedule quarterly 3rd party internal audits to ensure the above are in place and working as documented.

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1-16-2014

Date

Kane Tugate

Signature of Plaintiff